		FOR OHF USE					
0	1				1	7	7
0	1		1	1			3
	6	0	0	3	3	3	9

m

LL1

K2K3= 0107

V5= 00

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

V19= 0

CAS USED -- CHANGE 1/1/85

C13= MID AMERICA CARE

366 Days in the Cost Report Period

I. IDPH Facility ID Number: 0029322 m

Facility Name: FREEPORT MANOR m

Address: 900 S. KIWANIS DRIVE FREEPORT 61032 m
m Number City m Zip Code

County: STEPHENSON

Telephone Number: (815) 235-6196 Fax # (815) 235-5365

IDPA ID Number: m 510271905006

Date of Initial License for Current Owners:

Type of Ownership: V4= 0027854

Prior Owner Name=

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: STEVEN D. TENHOUSE, OLIVE Telephone Number: (217) 753-1375

C3= C4= Preliminary desk audit was completed MT 5/15/01

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07011999 to 06302000 m and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	CHAD BUTTERFIELD, THCSLLC, MGT. CO. FO
	(Title)	FREEPORT MANOR
Paid Preparer 45	(Signed)	(Date)
	(Print Name and Title)	OLIVE LLP
	(Firm Name & Address)	205 S. 5TH STREET, SUITE 645, SPRINGFIEL
	(Telephone)	(217) 753-1375 Fax # (217) 744-0193

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number FREEPORT MANOR # 0029322 Report Period Beginning: 07011999 Ending: 06302000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

366 Days in the Cost Report Period

	1 Beds at Beginning of Report Period		2 Licensure Level of Care	3 Beds at End of Report Period		4 Licensed Bed Days During Report Period		
1	m	143	Skilled (SNF)	143	m	52,338	1	xf
2			Skilled Pediatric (SNF/PED)				2	
3			Intermediate (ICF)				3	
4			Intermediate/DD				4	
5			Sheltered Care (SC)				5	
6			ICF/DD 16 or Less				6	
7	m	143	TOTALS	143	m	52,338	7	xf
				93% =		48674		

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	638	22	4,162	4,822	8
9	SNF/PED					9
10	ICF	21,718	12,762		34,480	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,356	12,784	4,162	39,302	14
		56.88%				

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.09%

61 Public Aid Patients

43057 1999 Total Patient Days

D. How many bed-hold days during this year were paid by Public Aid? (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

N/A

F. Does the facility maintain a daily midnight census? Y

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO X

I. On what date did you start providing long term care at this location?

Date started 11/1/85

J. Was the facility purchased or leased after January 1, 1978?

YES X Date 11/1/85 NO

K. Was the facility certified for Medicare during the reporting year?

YES X NO If YES, enter number of beds certified 16 and days of care provided 4,162

C5= 1

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS MODIFIED

ACCRUAL X CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 6/30 Fiscal Year: 6/30

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number FREEPORT MANOR # 0029322 Report Period Beginning: 07011999 Ending: 06302000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar) 39,302 Patient Days

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY			Per Diems
	A. General Services	1	2	3	4	5	6	7	8	9	10		
1	Dietary	182,708	9,776	8,694	201,178		201,178	(1,661)	199,517		199,517	1	5.08
2	Food Purchase		168,694		168,694		168,694	(1,555)	167,139		167,139	2	4.25
3	Housekeeping	110,397	31,139		141,536		141,536		141,536		141,536	3	3.60
4	Laundry	56,461	20,325		76,786		76,786	(1,120)	75,666		75,666	4	1.93
5	Heat and Other Utilities			108,945	108,945		108,945	12	108,957		108,957	5	2.77
6	Maintenance	38,892	22,610	40,296	101,798		101,798		101,798		101,798	6	2.59
7	Other (specify):*			4,123	4,123		4,123		4,123		4,123	7	0.10
8	**TOTAL General Services**	388,458	252,544	162,058	803,060		803,060	(4,324)	798,736		798,736	8	20.32
	B. Health Care and Programs	See the bottom of Page 4 for the salary amounts to be used to calculate any rates for this facility											
9	Medical Director			14,330	14,330		14,330		14,330		14,330	9	0.36
10	Nursing and Medical Records	1,697,052	107,845	3,209	1,808,106		1,808,106		1,808,106		1,808,106	10	46.01
10a	Therapy											10a	
11	Activities	50,367	10,355	4,516	65,238		65,238		65,238		65,238	11	1.66
12	Social Services	46,390		3,048	49,438		49,438		49,438		49,438	12	1.26
13	Nurse Aide Training											13	
14	Program Transportation											14	
15	Other (specify):*											15	
16	**TOTAL Health Care and Programs**	1,793,809	118,200	25,103	1,937,112		1,937,112		1,937,112		1,937,112	16	49.29
	C. General Administration	See the bottom of Page 4 for the salary amounts to be used to calculate any rates for this facility											
17	Administrative	65,718	(59)		65,659		65,659		65,659		65,659	17	1.67
18	Directors Fees											18	
19	Professional Services			235,548	235,548		235,548	25,628	261,176		261,176	19	6.65
20	Dues, Fees, Subscriptions & Promotions			73,625	73,625		73,625	(33,936)	39,689		39,689	20	1.01
21	Clerical & General Office Expenses	102,616	26,558	115,143	244,317		244,317	(97,597)	146,720		146,720	21	3.73
22	Employee Benefits & Payroll Taxes			244,385	244,385		244,385		244,385		244,385	22	6.22
23	Inservice Training & Education											23	
24	Travel and Seminar			11,299	11,299		11,299	1,060	12,359		12,359	24	0.31
25	Other Admin. Staff Transportation			6,392	6,392		6,392		6,392		6,392	25	0.16
26	Insurance-Prop.Liab.Malpractice			64,242	64,242		64,242	2,154	66,396		66,396	26	1.69
27	Other (specify):*											27	
28	**TOTAL General Administration**	168,334	26,499	750,634	945,467		945,467	(102,691)	842,776		842,776	28	21.44
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,350,601	397,243	937,795	3,685,639		3,685,639	(107,015)	3,578,624		3,578,624	29	91.05

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

59.81 10.11 23.86

Facility Name & ID Number FREEPORT MANOR 0029322 Report Period Beginning: 07011999 Ending: 06302000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY			
	D. Ownership	1	2	3	4	5	6	7	8	9	10		
30	Depreciation			189,822	189,822		189,822	(180)	189,642		189,642	30	4.83
31	Amortization of Pre-Op. & Org.			44,654	44,654		44,654	(44,654)				31	
32	Interest			677,970	677,970		677,970	(25,493)	652,477		652,477	32	16.60
33	Real Estate Taxes											33	
34	Rent-Facility & Grounds											34	
35	Rent-Equipment & Vehicles			1,008	1,008		1,008	88	1,096		1,096	35	0.03
36	Other (specify):*											36	
37	**TOTAL Ownership**			913,454	913,454		913,454	(70,239)	843,215		843,215	37	21.45
	Ancillary Expense												
	E. Special Cost Centers	See the bottom of Page 4 for the salary amounts to be used to calculate any rates for this facility											
38	Medically Necessary Transportation											38	
39	Ancillary Service Centers		91,714	160,755	252,469		252,469	(2,040)	250,429		250,429	39	6.37
40	Barber and Beauty Shops											40	
41	Coffee and Gift Shops											41	
42	Provider Participation Fee			78,507	78,507		78,507		78,507		78,507	42	2.00
43	Other (specify):*											43	
44	**TOTAL Special Cost Centers**		91,714	239,262	330,976		330,976	(2,040)	328,936		328,936	44	8.37
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,350,601	488,957	2,090,511	4,930,069		4,930,069	(179,294)	4,750,775		4,750,775	45	120.88
	Totals actually entered in masterfile due to the transfer of facility adj.'s and reclasses	2,350,601	488,957	2,090,511				(179,294)			4,750,775		
		59.81	12.44	53.19									

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Cost of Background Checks = L1= 6027
Not Being Used at this Time M10=
Electronic CR Batch # M11= 3

General Services Salaries % of Total	16.53%
Health Care and Programs Salaries % of Total	76.31%
General Administration Salaries % of Total	7.16%
Employee Benefits % of Total Salaries	10.40%

PPF: 1.5 x 52338 = 78507

		As Filed	Adj/Reclass	Revised Amt
V40	Sch V Line 8, col. 1	388,458		388,458
V53	Sch V Line 16, col. 1	1,793,809		1,793,809
V62	Sch V Line 28, col. 1	168,334		168,334
C10	Sch V Line 29, col. 1	2,350,601		2,350,601
D01	Sch V Line 44, col. 1			
D02	Sch V Line 45, col. 1	2,350,601		2,350,601
M01	Sch V Line 10, col. 1	1,697,052		1,697,052
J01	Sch V Line 10A, col. 1			
C12	Sch V Line 45, col. 7	(179,294)		(179,294)

Use the Revised salary amounts from col. K to calculate any rates for this facility

Facility Name & ID Number FREEPORT MANOR # 0029322 Report Period Beginning: 07011999 Ending: 06302000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,661)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients	(2,040)	39		7
8	Laundry for Non-Patients	(1,120)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(22,707)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		32		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(37,002)	21		18
19	Entertainment				19
20	Contributions		21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,000)	21		24
25	Fund Raising, Advertising and Promotional	(33,936)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,189)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (105,655)		$	30

OHF USE ONLY								
48		49	3	50	86	51	6	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense	(44,654)	31	33
34	Adjustments for Related Organization Costs (Schedule VII)	(28,985)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (73,639)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (179,294)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$	0	38
39					0	39
40	Gift and Coffee Shops				0	40
41	Barber and Beauty Shops				0	41
42	Laboratory and Radiology				0	42
43	Prescription Drugs				0	43
44	Exceptional Care Program				0	44
45	Other-Attach Schedule				0	45
46	Other-Attach Schedule				0	46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Adjustments made by OHF

FREEPORT MANOR

ID# 0029322

Report Period Beginning: 07011999

Ending: 06302000

	NON-ALLOWABLE EXPENSES & RECLASSIFICATIO	Amount	Sch. V Line Reference	
A8	Non-Working Officer's or Owner's Salary	$	Detail Below	A8
	Facility Adjustments for Related Organization	(28,985)	Pg 5, Line 34	
	OHF Adjustments to the Related Org. Expenses		Detail Below	
A9	Sum of Facility and OHF Adj's to the Related Org	(28,985)		A9
1				1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44	**Total**	0		44

Facility Name & ID Number FREEPORT MANOR # 0029322 Report Period Beginning: 07011999 Ending: 06302000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
	0.00	SEE ATTACHED LISTING				
	0.00					
	0.00					
	0.00					
	0.00					
	0.00					
	0.00					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Column 8 Crossfoot
1	V	5	HEAT AND OTHER UTILI	$	MIDAMERICA CARE FOUNDATION	100.00%	$ 12	$ 12	1	12
2	V	19	PROFESSIONAL SERVICE		MIDAMERICA CARE FOUNDATION	100.00%	25,628	25,628	2	25,628
3	V	21	CLERICAL & OTHER GEN	55,427	MIDAMERICA CARE FOUNDATION	100.00%	286	(55,141)	3	(55,141)
4	V	24	TRAVEL AND SEMINAR		MIDAMERICA CARE FOUNDATION	100.00%	1,060	1,060	4	1,060
5	V	26	INSURANCE		MIDAMERICA CARE FOUNDATION	100.00%	2,154	2,154	5	2,154
6	V	32	INTEREST EXPENSE		MIDAMERICA CARE FOUNDATION	100.00%	(2,786)	(2,786)	6	(2,786)
7	V	35	RENT-EQUIPMENT		MIDAMERICA CARE FOUNDATION	100.00%	88	88	7	88
8	V								8	
9	V								9	
10	V								10	
11	V								11	
12	V								12	
13	V								13	
14	Total			$ 55,427			$ 26,442	$ * (28,985)	14	(28,985)

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FREEPORT MANOR # 0029322 Report Period Beginning: 07011999 Ending: 06302000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Column 8 Crossfoot
15	V			$			$	$	15	
16	V								16	
17	V								17	
18	V								18	
19	V								19	
20	V								20	
21	V								21	
22	V								22	
23	V								23	
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$			$	$ *	39	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number FREEPORT MANOR # 0029322 Report Period Beginning: 07011999 Ending: 06302000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MICHAEL A. MICHAUD	DIRECTOR	PRESIDENT					BOD FEES	$	LN 19, COL. 3	1
2	W. TERRENCE BROWN	DIRECTOR	SECRETARY					BOD FEES		LN 19, COL. 3	2
3	EDWARD T. WEAVER	DIRECTOR	TREASURER					BOD FEES		LN 19, COL. 3	3
4	DONALD A. UDSTUEN	DIRECTOR						BOD FEES		LN 19, COL. 3	4
5	MICHAEL F. FLANAGAN		ASST. SECRETAI					BOD FEES		0	5
6										0	6
7										0	7
8										0	8
9										0	9
10										0	10
11										0	11
12										0	12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

NOTE: BOD fees are not owners comp thus deleted here.

ILLINOIS DEPARTMENT OF PUBLIC AID

FINANCE SECTION

MT 5/15/01

H F N 0 0 8 **MASTER FILE FIELD INFORMATION**

FREEPORT MANOR

SEQ. NBR	TRANS-ACTION CODE	FACILITY IDENTIFICATION NUMBER	EFFECTIVE DATE YEAR	EFFECTIVE DATE MONTH
N	A	7N-C	4N-C	
1	A	0 0 2 9 3 2 2	0 1	0 7
7	8	9 15	16	19
		MANDATORY	MANDATORY	

FIELD NUMBER 4C-C	FIELD VALUE 15A-C	
J 0 0 6		ADMINISTRATOR
20 23	24 38	
J 0 0 7		OWNER
39 42	43 57	
J 0 0 8		OWNER
58 61	62 76	
J 0 0 9		OWNER
77 80	81 95	
J 0 1 0		OWNER
96 99	100 114	
J 0 1 1		OWNER
115 118	119 133	
J 0 1 2		OWNER
134 137	138 152	

Facility Name & ID Number FREEPORT MANOR # 0029322 Report Period Beginning: 07011999 Ending: 06302000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MIDAMERICA CARE FOUNDATION
Street Address: 7611 STATE LINE ROAD
City / State / Zip Code: KANSAS CITY, MISSOURI 64114
Phone Number: (816) 444-0900
Fax Number: (816) 822-8799

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		Column 9 Crossfoot
1	5	HEAT AND OTHER UTILI	PATIENT DAYS	405,210	13	$ 121	$	39,302	$ 12	1	12
2	19	PROFESSIONAL SERVICE	PATIENT DAYS	405,210	13	264,226		39,302	25,628	2	25628
3	21	CLERICAL & OTHER GEN	PATIENT DAYS	405,210	13	2,944		39,302	286	3	286
4	24	TRAVEL AND SEMINAR	PATIENT DAYS	405,210	13	10,926		39,302	1,060	4	1060
5	26	INSURANCE	PATIENT DAYS	405,210	13	22,213		39,302	2,154	5	2154
6	32	INTEREST EXPENSE	PATIENT DAYS	405,210	13	(28,728)		39,302	(2,786)	6	-2786
7	35	RENT-EQUIPMENT	PATIENT DAYS	405,210	13	912		39,302	88	7	88
8	0				0					8	
9	0				0					9	
10	0				0					10	
11	0				0					11	
12	0				0					12	
13	0				0					13	
14	0				0					14	
15	0				0					15	
16	0				0					16	
17	0				0					17	
18	0				0					18	
19	0				0					19	
20	0				0					20	
21	0				0					21	
22	0				0					22	
23	0				0					23	
24	0				0					24	
25	TOTALS					$ 272,614	$		$ 26,442	25	

G3= 272,614
Prior Year G3 347,361

G4= 26,442
Prior Year G4 31,360

STATE OF ILLINOIS

Facility Name & ID Number FREEPORT MANOR # 0029322 Report Period Beginning: 07011999 Ending: 06302000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		Column 9 Crossfoot
1	0				0	$	$		$	1	
2	0				0					2	
3	0				0					3	
4	0				0					4	
5	0				0					5	
6	0				0					6	
7	0				0					7	
8	0				0					8	
9	0				0					9	
10	0				0					10	
11	0				0					11	
12	0				0					12	
13	0				0					13	
14	0				0					14	
15	0				0					15	
16	0				0					16	
17	0				0					17	
18	0				0					18	
19	0				0					19	
20	0				0					20	
21	0				0					21	
22	0				0					22	
23	0				0					23	
24	0				0					24	
25	TOTALS					$	$		$	25	

Facility Name & ID Number FREEPORT MANOR # 0029322 Report Period Beginning: 07011999 Ending: 06302000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	FREEPORT CLASS 6(B)		X	MORTGAGE		1/1/85	$ 3,700,000	$ 3,936,706	12/01/15	0.135	$ 531,455	1
2												2
3												3
4												4
5												5
	Working Capital											
6	INTEREST INCOME		X								(22,707)	6
7	H/O INTEREST INCOME	X									(2,786)	7
8	BANK OF AMERICA LOC		X	W/C CONSTRUCTIO				1,641,220		0.0875	146,515	8
9	TOTAL Facility Related						$ 3,700,000	$ 5,577,926			$ 652,477	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,700,000	$ 5,577,926			$ 652,477	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number FREEPORT MANOR # 0029322 Report Period Beginning: 07011999 Ending: 06302000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

366 Days in the Cost Report Period

1. Real Estate Tax accrual used on 1999 report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

X = Agrees to applicable years' tax bill

Real Estate Tax Bill for Calendar Year:			
	1995		8
	1996		9
% increase - 1999/1998	1997		10
	1998		11
	1999		12

If you allow an amount for taxes that is different from the amount the facility filed on its 1999 R.E. tax statement, **please change the log accordingly**.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Prorate Real Estate Taxes Below, if Necessary

Days/365	1999 R.E Tax Amt		Allowable Amt
1.00 X		=	

Facility Name & ID Number FREEPORT MANOR # 0029322 Report Period Beginning: 07011999 Ending: 06302000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,450 / 213 (Square footage per bed) x B. General Construction Type: Exterior BRICK AND Frame Number of Stories 2

C. Does the Operating Entity? X (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

V113= 1 yes Does the answer to question C agree to the IDPH ownership listing?

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? X (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? X YES NO

If so, please complete the following:

1. Total Amount Incurred: 683,117
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 44,654
4. Dates Incurred: VARIOUS

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

x = agrees to the field audit (Enter x's next to the building square footage amount and the land information)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$ a 91,010	1
2					2
3	TOTALS			$ 91,010	3

If the current owner of the facility has not been field audited, enter NA in the box above and tie back to previous reports.

a represents reallocated purchase price. back to '86 report sq footage ties '86 FA. In view of large '97 bed add, this figure likely understated. -- XA

Facility Name & ID Number FREEPORT MANOR # 0029322 Report Period Beginning: 07011999 Ending: 06302000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

		1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
Total Beds 143	4	116		1985	1971	$ 1,844,150	$		$	$	$	4
	5	27		1997	1997	1,283,650						5
	6			1985	1985	74,846						6
m	7			1986	1986	5,601						7
	8											8
		Improvement Type**										
V115= 1987 per 1999 rept CAS In cells A18 & A19, detail where V115= comes from.	9				1985	27,210						9
	10				1986	825						10
	11				1988	2,440						11
	12				1989	3,190						12
	13				1990	17,268						13
	14				1991	32,793						14
	15				1992	627						15
	16				1993	16,433						16
	17				1994	73,875						17
	18				1995	41,480						18
	19				1996	3,891						19
	20				1997	8,450						20
	21				1998	18,961						21
	22				1999	50,279						22
	23				2000	779						23
	24											24
	25											25
	26											26
	27											27
	28											28
	29											29
	30											30
	31											31
	32											32
	33											33
	34											34
	35											35
	36											36

This page was created by OHF for data entry purposes.

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Line 70 for Totals-Pg 12A

V199= 1

M12= Mgmt Co allocated cost

Facility Name & ID Number FREEPORT MANOR # 0029322 Report Period Beginning: 07011999 Ending: 06302000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37				$	$		$	$	$	37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)	1990.14	37846	$ 3,506,748	$		$	$	$	70

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete 24,523 per bed

Facility Name & ID Number FREEPORT MANOR # 0029322 Report Period Beginning: 07011999 Ending: 06302000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 515,555	$	$	$		$ 319,864	37
38	Current Year Purchases	33,727					2,194	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 549,282	$ 34,053	$ 38,586	$ 4,533		$ 322,058	41

3841 Per Bed

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42			93	$ 20,847	$	$	$		$ 20,847	42
43										43
44										44
45										45
46	TOTALS			$ 20,847	$ 1,737	$ 2,978	$ 1,241		$ 20,847	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 4,167,887	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 189,822	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 189,642	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (180)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58	WIP	$ 341,478	58
59			59
60			60
61		$ 341,478	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number FREEPORT MANOR # 0029322 Report Period Beginning: 07011999 Ending: 06302000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO V209=

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

Lease Cost Per Day

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO V231=

16. Rental Amount for movable equipment: $ 1,008 Description: SEE ATTACHED DETAIL
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

V234=

Please Note:
If the facility rents the site and building from a related party, delete the variables from this page related to this lease. Also remove any "NA text" that are in the variable fields.

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number FREEPORT MANOR # 0029322 Report Period Beginning: 07011999 Ending: 06302000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

C46= 1

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE [ ]

C47=

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE [ ]

C49=

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number FREEPORT MANOR # 0029322 Report Period Beginning: 07011999 Ending: 06302000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Col. Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs		$	3,222	$ 64,438	$	3,222	$ 64,438	1
2	Licensed Speech and Language Development Therapist		hrs			337	7,414		337	7,414	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs			5,790	86,843	1,322	5,790	88,165	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL				$	9,349	$ 158,695	$ 1,322	9,349	$ 160,017	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number FREEPORT MANOR # 0029322 Report Period Beginning: 07011999 Ending: 06302000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06302000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 181,435	$	1
2	Cash-Patient Deposits	1,000		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	761,142		3
4	Supply Inventory (priced at)	20,548		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 964,125	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	3,953,778		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,015,939		16
17	Accumulated Depreciation (book methods)	(2,263,273)		17
18	Deferred Charges	683,117		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	1,723		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,391,284	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,355,409 m	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 206,628	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,733,871		29
30	Accrued Salaries Payable	160,873		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	OTHER LIAB.'S A	6,003		36
37	DUE TO AFFILIAT			37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,107,375	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,641,220		39
40	Mortgage Payable	3,936,706		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,577,926	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,685,301	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,329,892) m	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,355,409 m	$	48

Current Ratio 0.31027

*(See instructions.)

Facility Name & ID Number FREEPORT MANOR # 0029322 Report Period Beginning: 07011999 Ending: 06302000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total			
				0007 amount from Page 17, line 47	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,117,027)	1	m -3,117,027	
2	Restatements (describe):		2		
3			3		
4			4		
5			5		
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,117,027)	6		
	A. Additions (deductions):				
7	NET Income (Loss) (from page 19, line 43)	(1,212,864)	7		
8	Aquisitions of Pooled Companies		8		
9	Proceeds from Sale of Stock		9		
10	Stock Options Exercised		10		
11	Contributions and Grants		11		
12	Expenditures for Specific Purposes		12		
13	Dividends Paid or Other Distributions to Owners	( )	13		
14	Donated Property, Plant, and Equipment		14		
15	Other (describe)	(1)	15		
16	Other (describe)		16		
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,212,865)	17		
	B. Transfers (Itemize):				
18			18		
19			19		
20			20		
21			21		
22			22		
23	**TOTAL Transfers (sum of lines 18-22)**	$	23		
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (4,329,892)	24	*	

*** This must agree with page 17, line 47.**

Facility Name & ID Number FREEPORT MANOR # 0029322 Report Period Beginning: 07011999 Ending: 06302000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount		Expenses	2 Amount	
	A. Inpatient Care			**A. Operating Expenses**		
1	Gross Revenue -- All Levels of Care	$ 4,033,835	1	31 General Services	803,060	31
2	Discounts and Allowances for all Levels	(723,597)	2	32 Health Care	1,937,112	32
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,310,238	3	33 General Administration	945,467	33
	B. Ancillary Revenue			**B. Capital Expense**		
4	Day Care		4	34 Ownership	913,454	34
5	Other Care for Outpatients		5	**C. Ancillary Expense**		
6	Therapy	355,586	6	35 Special Cost Centers	252,469	35
7	Oxygen	680	7	36 Provider Participation Fee	78,507	36
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 356,266	8	**D. Other Expenses (specify):**		
	C. Other Operating Revenue			37		37
9	Payments for Education		9	38		38
10	Other Government Grants		10	39		39
11	Nurses Aide Training Reimbursements		11			
12	Gift and Coffee Shop		12	40 **TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,930,069	40
13	Barber and Beauty Care		13			
14	Non-Patient Meals	1,660	14	41 **Income before Income Taxes (line 30 minus line 40)****	(1,212,864)	41
15	Telephone, Television and Radio		15			
16	Rental of Facility Space		16	42 **Income Taxes**		42
17	Sale of Drugs		17			
18	Sale of Supplies to Non-Patients	2,040	18	43 **NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,212,864)	43
19	Laboratory		19			
20	Radiology and X-Ray		20			
21	Other Medical Services		21			
22	Laundry	1,120	22			
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 4,820	23			
	D. Non-Operating Revenue					
24	Contributions		24			
25	Interest and Other Investment Income***	22,707	25			
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 22,707	26			
	E. Other Revenue (specify):**					
27	Settlement Income (Insurance, Legal, Etc.)		27			
28	EXTRAORDINARY I	23,203	28			
28a	G/L ON SALE OF	(29)	28a			
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 23,174	29			
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,717,205	30			

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number FREEPORT MANOR # 0029322 Report Period Beginning: 07011999 Ending: 06302000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	5,838	6,394	$ 135,691	$ 21.22	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,112	9,690	318,806	32.90	3
4	Licensed Practical Nurses	15,489	16,584	379,330	22.87	4
5	Nurse Aides & Orderlies	61,401	65,118	837,425	12.86	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	5,239	5,946	50,367	8.47	9
10	Activity Assistants					10
11	Social Service Workers	3,523	3,642	46,390	12.74	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,312	22,317	182,708	8.19	15
16	Dishwashers					16
17	Maintenance Workers	2,262	2,425	38,892	16.04	17
18	Housekeepers	13,657	15,705	110,397	7.03	18
19	Laundry	8,166	8,207	56,461	6.88	19
20	Administrator	2,156	2,188	65,718	30.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,020	8,036	102,616	12.77	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,733	2,733	25,800	9.44	31
32	Other Health Ca					32
33	Other(specify)			1		33
34	TOTAL (lines 1 - 33)	159,908	168,985	$ 2,350,601 *	$ 13.91	34
	Total (Lines 1-33) after lines removed	159908	168985	2350602	13.91	

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

Please Delete col 1 total if there are not hours for every consultant that has a cost.

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference		Per Hour
35	Dietary Consultant	224	$ 8,694	line	35	38.81
36	Medical Director	197	14,330	line	36	72.74
37	Medical Records Consultant	9	415	line	37	46.11
38	Nurse Consultant				38	
39	Pharmacist Consultant	65	953	line	39	14.66
40	Physical Therapy Consultant				40	
41	Occupational Therapy Consultant				41	
42	Respiratory Therapy Consultant				42	
43	Speech Therapy Consultant				43	
44	Activity Consultant	56	3,553	line	44	63.45
45	Social Service Consultant	63	3,048	line	45	48.38
46	Other(specify)				46	
47					47	
48					48	
49	TOTAL (lines 35 - 48)	614	$ 30,993		49	

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference		Per Hour
50	Registered Nurses	1,555	$ 110,001	Ln 10	50	70.74
51	Licensed Practical Nurses	1,556	82,443	Ln 10	51	52.98
52	Nurse Aides	4,672	182,659	Ln 10	52	39.10
53	TOTAL (lines 50 - 52)	7,783	$ 375,103		53	

Items not entered into the database

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MAUPIN, JEREMY	ADMINISTRATOR		$ 65,718
TOTAL (agree to Schedule V, line 17, col. 1		V339=	65,718
(List each licensed administrator separately.)			$ 65,718

B. Administrative - Other

V340=

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
VARIOUS	PURCH SERV	$ 366
TUTERA HEALTH C	MANAGEMENT FEES	203,232
VARIOUS	LEGAL FEES	4,531
VARIOUS	ACCOUNTING FEES	10,741
VARIOUS	D/P FEES	10,087
VARIOUS	PROFESSIONAL SE	1,899
VARIOUS	TRUSTEE EXPENSE	4,693
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 235,549

ALLOWABLE LEGAL A17= 4531

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Comp. Insurance	3.07%	$ 72,117
Unemployment Comp. Insurance	0.46%	10,735
FICA Taxes	6.20%	145,737
Employee Health Insurance	0.45%	10,642
Employee Meals		
Ill Municipal Rtmt Fund (IMRF)*		
OTHER BENEFITS	0.22%	5,153
HOME OFFICE ALL		
TOTAL (agree to Schedule V, line 22, col.8)	10.40%	$ 244,384

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 93
Advertising: Employee Recruitment	26,402
Health Care Worker Background Check	6,027
(Indicate # of checks performed 502)	
DUES & SUBSCRIP	6,285
ADVERTISING PR	34,817
RECLASSIFICATIO	
Less: Public Relations Expense	
Non-allowable advertising	(33,936)
Yellow page advertising	
TOTAL (agree to Sch. V, line 20, col. 8)	$ 39,688

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	11,299
HOME OFFICE ALL	1,060
Seminar Expense	
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,359

**See instructions.

Facility Name & ID Number FREEPORT MANOR # 0029322 Report Period Beginning: 07011999 Ending: 06302000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$	0	$	$	$	$	$	$	$	$	$
2				0									
3				0									
4				0									
5				0									
6				0									
7				0									
8				0									
9				0									
10				0									
11				0									
12				0									
13				0									
14				0									
15				0									
16				0									
17				0									
18				0									
19				0									
20	TOTALS		$		$	$	$	$	$	$	$	$	$

G71=

Facility Name & ID Number FREEPORT MANOR # 0029322 Report Period Beginning: 07011999 Ending: 06302000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? N

B17= 2

(2) Are there any dues to nursing home associations included on the cost report? N
If YES, give association name and amount.

B18= 9

(3) Did the nursing home make political contributions or payments to a political action organization? N If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? N If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? Y
What was the average life used for new equipment added during this period? 7 YEARS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 1,423 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Y If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? N
If YES, give effective date of lease. 0

(9) Are you presently operating under a sublease agreement? YES N NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO N If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 78,507
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? N If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Y

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? N For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? Y Indicate the amount. $ 1,660

(16) Travel and Transportation

a. Are there costs included for out-of-state travel? N
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? N If YES, please indicate the amount of income earned from such a program during this reporting period. $

c. What percent of all travel expense relates to transportation of nurses and patients?

d. Have vehicle usage logs been maintained? N/A

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Y

g. Does the facility transport residents to and from day training? N
Indicate the amount of income earned from providing such transportation during this reporting period. $

H8= 1

(17) Has an audit been performed by an independent certified public accounting firm? Y
Firm Name: DONNELLY, MEINERS, JORDAN & KLINE The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N If no, please explain. NOT YET COMPLETED

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Y

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? Y
Attach invoices and a summary of services for all architect and appraisal fees.